**City of Memphis**
**Human Resources Division**
**125 N. Main Street, Room 1B-33**
**Memphis, Tennessee 38103**

*Personal & Confidential*

You have been scheduled for the next phase in the pre-employment process for Police Recruit, which is the Pre-Medical Screening/Laboratory Tests and Tentative Medical Examination. You are to report for this testing according to the following schedule:

**ARRIVE PROMPTLY - total testing time can vary from 3 to 5 hours**
**LOCATION**: Concentra Medical Center, 2831 Airways Blvd
Building A, Suite 102
Memphis, Tennessee 38132
(901) 348-0800

READ AND FOLLOW INSTRUCTIONS:

1. **Fill out completely the attached Medical History Statement and bring it to your appointment**
2. You must present **this letter** and a valid, photo identification to be admitted to the Pre-Medical Screening and Lab Testing
3. You must fast eight (8) hours prior to your Pre-Medical Screening/Laboratory testing. This includes NO beverages that contain caffeine the morning of the exam. A small amount of water is the only acceptable drink. You must have NO ALCOHOLIC BEVERAGES from NOW until after the laboratory tests are completed.
4. You must not bring or wear any valuables to the Pre-Medical Screening/Laboratory Tests and Tentative Medical Examination, including watches, other jewelry or wallets. You will also complete a treadmill test, so wear appropriate shoes are required.
5. Stop all exercise programs and be inactive physically for the week prior to your scheduled date above, until lab tests are completed, as this does affect the findings. Do NOT lift anything heavy for several days prior to the lab work.
6. Try not to do anything strenuous or anything that would cause eyestrain for several days prior to your appointment. You need to report to this event relaxed and well-rested.
7. **Female Applicants:** You must not wear hosiery of any kind to laboratory testing since it may cause distortion in the results.
8. Individuals who wear contact lens must remove the lens at least twenty-four(24) hours prior to the Pre-Medical Screening to ensure proper examination of the uncorrected vision. Bring the contact lens and necessary solutions for checking of corrected vision. Individuals who wear eyeglasses only, **must bring** the eyeglasses to the Pre-Medical Screening.
9. If you have received medical treatment and/or surgery for an injury or illness, you must bring a **factual documentation summary letter** from the attending physician. The letter should detail the date of injury/illness, nature of treatment, length of care, and medications prescribed. A summary cover letter should be included with copies of medical records. THe physician should address prognosis as to reoccurrence and/or future injury; current range of motion and flexibility(if applicable); degree of seriousness of future injuries; etc.

NOTE: If you **do not** pass the Pre-Medical Screening portion(vision, blood pressure), you **will not** undergo laboratory tests and you **will not** undergo a Medical Exam.

**City of Memphis**
**Human Resources Division**
**125 N. Main Street, Room 1B-33**
**Memphis, Tennessee 38103**

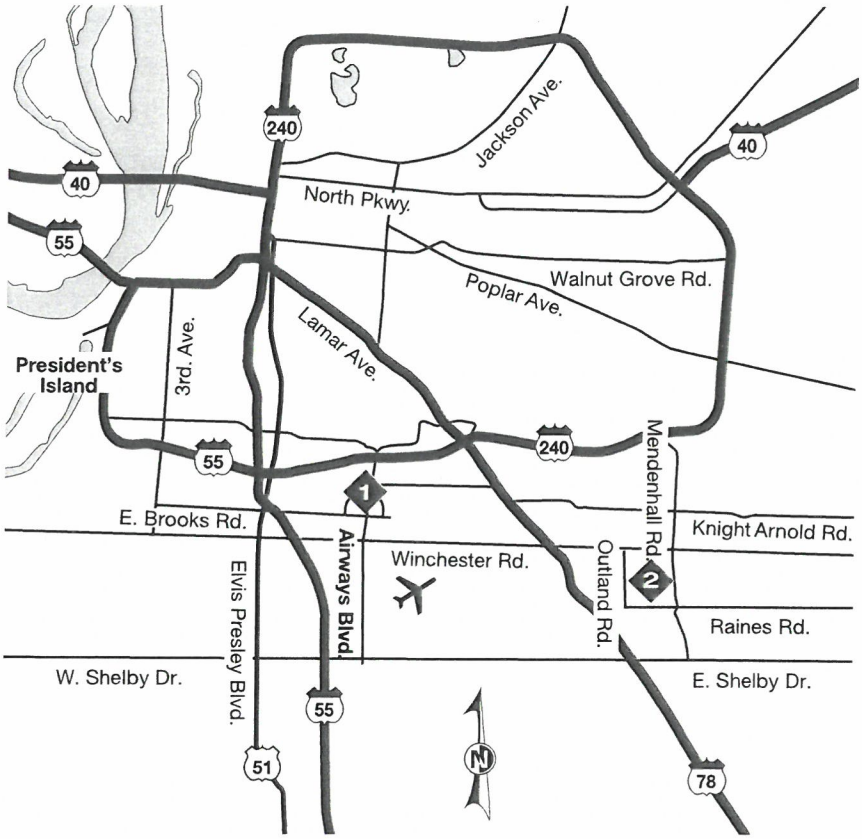
Please list here several telephone numbers where you can be reached during the day, or another person that can be reached during the day and get a message to you:

Your Name:
Cellphone:
Home Phone:
Work Telephone:
Additional Point of Contact #1: Person to ask for:
Additional Point of Contact #2: Person to ask for:

**IMPORTANT**: You will need to be available to be reached at one of the above telephone numbers the next several days following your lab tests. We will be calling about one-half of the applicants to schedule repeat tests and you must be available to report for repeats. **You should continue the No exercise, inactive, NO alcohol regimen.**

**BRING THIS LETTER AND THE COMPLETE MEDICAL HISTORY WITH YOU TO THE TEST.**

# Memphis Locations




**1** Concentra
Airport Memphis
2831 Airways Blvd.
Bldg. A, Suite 102
Memphis, TN 38132
Mon - Fri: 8 am - 6 pm
901.348.0200
Fax: 901.348.0046

**2** Concentra
South Mendenhall Road
3965 S. Mendenhall Rd.
Suite 6 Bldg. G
Memphis, TN 38115
* Located in the East Pointe Center
Mon - Fri: 8 am - 6 pm
901.365.1800
Fax: 901.365.1862

- Work-related injuries receive immediate triage assessment
- Pre-placement and DOT exams forms are provided, or you may use your company's specific forms
- No contract is required when working with Concentra. Our fees are competitive and adhere to the applicable state workers' compensation fee guidelines
- Visit Concentra.com/Our-Locations for a list of locations and turn-by-turn driving instructions.

Concentra
www.concentra.com

# Memphis Police Department

## Medical Consent and Release Form

I, _____, do hereby give my consent to the Memphis Police Department and its duly authorized representative to conduct a pre/post - employment physical examination which will include a laboratory test to determine alcohol or substance use. The results of the examination shall be released to the Manager of Police Employment, and will be a factor in determining my suitability for the position for which I have applied.

## Medications

| Name of Drug | Condition for which taken | Non Prescription (over the counter) | Prescription | Prescribing Doctor |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Important Laboratory Instructions:** At the medical examination, a urine specimen will be collected; therefore please keep in mind that you will be required to provide this urine by voiding your bladder at your scheduled appointment time.

**I have taken or am taking the above medications within the past thirty (30) days.**

Signature of Applicant/Employee Date

Signature of witness Date

***For Females Only*** Are you pregnant? Yes ____ No _____

# Appendix B:

## Pre-Placement Examination for the Job of Law Enforcement Officer

### MEDICAL HISTORY FORM

Name: _____
Last First Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

E-mail address: _____

Date of birth: _____

Gender: ☐ Male ☐ Female

**1. Work History**

**1.1 – Work History or jobs held since high school:**

| Dates | Job Title | Brief Description of Work |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**1.2 – Have you ever been exposed to fumes, chemicals, dusts, heavy metals, or radiation in your work or hobbies?**

☐ Yes ☐ No If yes, list types of exposure: _____

_____

**1.3 – Military Service:**

Were you in the military? ☐ Yes ☐ No If yes, for how long? _____

Job titles _____

What was your rank on discharge? _____

Did you receive your VA disability rating? ☐ Yes ☐ No

Have you been rejected or discharge for military service for medical or psychological reasons? ☐ Yes ☐ No

If yes, please give date and reason: _____

_____

## 2. SOCIAL HISTORY

### 2.1 – Fitness history

List Hobbies: _____

_____

List Sports and Recreational Activities in which you participate: _____

_____

How many times a week do you engage in a physical activity vigorous enough to work up a sweat? _____

### 2.2 – Smoking

Do you currently use tobacco products? ☐ Yes ☐ No

Have you ever used tobacco products in the past? ☐ Yes ☐ No

How many packs a day do you currently or did you previously smoke? _____

When did you start smoking? _____

When did you quit smoking? (if applicable) _____

### 2.3 – Alcohol

Do you drink alcohol beverages? ☐ Yes ☐ No

Amount per week: _____

### 2.4 – Caffeinated Drinks

Do you drink caffeinated beverages? ☐ Yes ☐ No

Amount per day: _____

### 2.5 – Drugs

Have you ever used any controlled substance not prescribed by a physician? ☐ Yes ☐ No

If yes, please specify the controlled substance(s): _____

### 2.6 – Disability

Have you ever applied for disability? ☐ Yes ☐ No

Have you ever received workers' compensation benefits? ☐ Yes ☐ No

Have you ever received compensation or settlement for an injury or any medical condition? ☐ Yes ☐ No

Have you ever been denied life or health insurance or offered it only at additional rates? ☐ Yes ☐ No

Have you ever been disqualified or discharged from the armed forces for medical reasons? ☐ Yes ☐ No

Have you ever had to change jobs for medical reasons? ☐ Yes ☐ No

Are you currently disabled? ☐ Yes ☐ No

How many workdays did you miss in the past 2 years for medical reasons? ☐ Yes ☐ No

Have you ever been out of work because of injury, illness, or other medical reason for more than 3 days? ☐ Yes ☐ No

Have you ever had your job modified because of injury, illness, or other medical reason? ☐ Yes ☐ No

If you answered yes to any of these questions, please explain: _____

_____

_____

Do you need any accommodation in order to perform the essential job functions of law enforcement officer with _____ [Agency name]? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

## 3. HEALTH HISTORY

### 3.1 – Medications

Have you been prescribed any medication within the past 5 years? If none, check "NONE."

☐ NONE

If yes, please explain (name of medication, dose, date when started, duration of treatment, reason for treatment):

_____

_____

_____

_____

_____

_____

_____

Are you taking any medication (prescription and non-prescription) on a regular basis (more than 3 times a week)? If none, check "NONE."

☐ NONE

If yes, please explain (name of medication, dose, date when started, duration of treatment, reason for treatment):

_____

_____

_____

_____

_____

_____

_____

Supplements and vitamins – Have you been taking any supplement or vitamin on a regular basis (more than once a week) within the past 5 years? If none, check "NONE."

☐ NONE

If yes, please explain:

_____

_____

_____

_____

_____

**3.2 – Surgeries**

Have you ever had, or been advised to have, surgery (including outpatient procedure)? ☐ Yes ☐ No

If yes, please explain (type of surgery, date, reason for surgery, name of hospital)

**3.3 – Hospitalizations**

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain (reason for hospitalization, diagnosis, date, name of hospital)

**3.4 – Emergency Department Visits**

Have you been to an emergency department in the past 10 years? ☐ Yes ☐ No

If yes, please explain (reason for visit, diagnosis, date, name of hospital)

**3.5 – General Issues**

Are you currently treated for any medical condition? ☐ Yes ☐ No

If yes, please explain:

Are you currently treated for any mental health condition? ☐ Yes ☐ No

If yes, please explain:

Are you currently under the care of health care professionals? ☐ Yes ☐ No

If yes, please write their name, specialties and phone numbers:

Have you received any medical treatment or therapy or visited a doctor, physician, health care provider or alternative medicine provider during the past 5 years? ☐ Yes ☐ No

If yes, please explain:

### 3.6 – Organ Systems

**Females only:** Are you pregnant? ☐ Yes ☐ No

Have you ever had or have you now any of the following?

**General Condition**

| | | Yes | No | If yes, provide details with date of onset and date of recovery |
|---|---|---|---|---|
| 1 | Recent gain or loss of weight | | | |
| 2 | Cancer | | | |
| 3 | Diabetes | | | |
| 4 | High blood sugar | | | |
| 5 | Tuberculosis | | | |
| 6 | Thyroid disease | | | |
| 7 | Positive tuberculin skin test | | | |
| 8 | Low blood sugar | | | |
| 9 | Adrenal gland disease | | | |
| 10 | Mumps | | | |
| 11 | Measles | | | |
| 12 | Poliomyelitis | | | |
| 13 | Hyponatremia (low sodium) with exertion | | | |
| 14 | Parathyroid gland disease | | | |
| 15 | Pituitary gland disease | | | |
| 16 | Heat stroke | | | |
| 17 | Heat exhaustion | | | |
| 18 | High cholesterol | | | |
| 19 | High triglycerides | | | |

**Head, ears, nose, throat** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 20 | Wear a hearing aid in left ear | | | |
| 21 | Wear a hearing aid in right ear | | | |
| 22 | Frequent nosebleeds | | | |
| 23 | Bleeding gums | | | |
| 24 | Chronic sinus condition | | | |
| 25 | Hoarseness | | | |
| 26 | Persistent sore throat | | | |
| 27 | Loss of taste | | | |
| 28 | Loss of smell | | | |
| 29 | Trouble smelling odors | | | |
| 30 | Hearing difficulties | | | |
| 31 | Ringing in ears | | | |
| 32 | Perforated eardrum | | | |
| 33 | Persistent ear infection | | | |
| 34 | Seasonal allergies | | | |
| 35 | Dental condition other than cavities | | | |
| 36 | Cochlear implant | | | |
| 37 | Meniere's disease | | | |

**Eyes** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 38 | Eye surgery (PRK, LASIK or other) | | | |
| 39 | Eyeglasses | | | |
| 40 | Contact lenses | | | |
| 41 | Glaucoma | | | |
| 42 | Cataract | | | |
| 43 | Frequent eye irritation | | | |

| | | | | |
|---|---|---|---|---|
| 44 | Color blindness | | | |
| 45 | Double vision | | | |
| 46 | Eye injury | | | |
| 47 | Blindness | | | |
| 48 | Retinal detachment | | | |
| 49 | Optic neuritis | | | |
| 50 | Retinopathy | | | |

**Heart and blood vessels** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 51 | Heart attack | | | |
| 52 | Coronary artery disease | | | |
| 53 | Angina | | | |
| 54 | Stent in coronary artery | | | |
| 55 | Atrial fibrillation | | | |
| 56 | Supraventricular tachycardia | | | |
| 57 | Heart arrhythmia (heart beating irregularly) | | | |
| 58 | Palpitations | | | |
| 59 | Cardiomyopathy | | | |
| 60 | Congestive heart failure | | | |
| 61 | Cardiac surgery | | | |
| 62 | Wolff-Parkinson-White syndrome | | | |
| 63 | Chest pain | | | |
| 64 | Shortness of breath | | | |
| 65 | Swelling of legs or feet | | | |
| 66 | Heart murmur | | | |
| 67 | Rheumatic fever | | | |
| 68 | Pulmonary hypertension | | | |
| 69 | Pulmonary embolus | | | |
| 70 | Deep venous thrombosis (blood clot) | | | |
| 71 | Syncope (passing out) | | | |
| 72 | Cardiac arrest | | | |
| 73 | Abnormal electrocardiogram (EKG) | | | |
| 74 | Hypertension | | | |
| 75 | Chest pressure | | | |
| 76 | High or low blood pressure | | | |
| 77 | Raynaud's syndrome | | | |
| 78 | Pacemaker | | | |
| 79 | Implantable defibrillator | | | |
| 80 | Abnormal heart valve | | | |
| 81 | Heart skipping or missing a beat | | | |
| 82 | Heartburn or indigestion that is not related to eating | | | |
| 83 | Any other heart problem that you have been told about | | | |
| 84 | Any other symptoms that you think may be related to heart or circulation problems | | | |

**Lungs** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 85 | Pneumonia | | | |
| 86 | Chronic bronchitis | | | |
| 87 | Asthma or inhaler use | | | |
| 88 | Emphysema | | | |
| 89 | COPD | | | |

| | | | | |
|---|---|---|---|---|
| 90 | Coughing blood | | | |
| 91 | Broken ribs | | | |
| 92 | Wheezing | | | |
| 93 | Cystic fibrosis | | | |
| 94 | Silicosis | | | |
| 95 | Dust disease | | | |
| 96 | Asbestosis | | | |
| 97 | Pneumothorax (collapsed lung) | | | |
| 98 | Lung cancer | | | |
| 99 | Valley fever | | | |
| 100 | Any chest injuries or surgeries | | | |
| 101 | Any lung problem that you have been told about | | | |

**Gastrointestinal** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 102 | Abdominal trouble | | | |
| 103 | Abdominal pain | | | |
| 104 | Inflammatory bowel disease | | | |
| 105 | Colitis | | | |
| 106 | Crohn's disease | | | |
| 107 | Pancreatitis | | | |
| 108 | Ulcer | | | |
| 109 | Persistent nausea | | | |
| 110 | Persistent indigestion | | | |
| 111 | Acid reflux | | | |
| 112 | Vomiting blood | | | |
| 113 | Blood in stool | | | |
| 114 | Liver cirrhosis | | | |
| 115 | Hepatitis | | | |
| 116 | Gallstones | | | |
| 117 | Jaundice | | | |
| 118 | Loss of appetite | | | |
| 119 | Hernia | | | |
| 120 | Irritable bowel syndrome | | | |
| 121 | Gallbladder disease | | | |

**Genitourinary** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 122 | Kidney stone | | | |
| 123 | Kidney infection | | | |
| 124 | Blood in urine | | | |
| 125 | Prostate condition | | | |
| 126 | Endometriosis | | | |
| 127 | Polycystic kidney disease | | | |
| 128 | Kidney disease | | | |

**Blood disorders** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 129 | Sickle cell disease | | | |
| 130 | Sickle cell trait | | | |
| 131 | Anemia | | | |
| 132 | Blood transfusion | | | |
| 133 | Low platelet count | | | |
| 134 | Bleeding disorder | | | |
| 135 | Hemophilia | | | |
| 136 | Von Willebrand disease | | | |

**Nervous system** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 137 | Seizure | | | |
| 138 | Epilepsy | | | |
| 139 | Stroke | | | |
| 140 | Migraine | | | |
| 141 | Headaches | | | |
| 142 | Vertigo or motion sickness | | | |
| 143 | Dizziness | | | |
| 144 | Memory troubles | | | |
| 145 | Tremors | | | |
| 146 | Parkinson's disease | | | |
| 147 | Paralysis | | | |
| 148 | Numbness or tingling | | | |
| 149 | Weakness of body part | | | |
| 150 | Dyslexia | | | |
| 151 | Speech problem | | | |
| 152 | Stuttering | | | |
| 153 | Meningitis | | | |
| 154 | Encephalitis | | | |
| 155 | Concussion | | | |
| 156 | Traumatic brain injury | | | |
| 157 | Bleeding inside the skull | | | |
| 158 | Abnormal balance | | | |
| 159 | Abnormal coordination | | | |
| 160 | Multiple sclerosis | | | |
| 161 | Myasthenia gravis | | | |
| 162 | Aneurysm | | | |

**Musculoskeletal** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 163 | Broken bone | | | |
| 164 | Dislocation | | | |
| 165 | Spine surgery | | | |
| 166 | Arthritis | | | |
| 167 | Bursitis | | | |
| 168 | Tendonitis | | | |
| 169 | Back pain | | | |
| 170 | Ankylosing spondylitis | | | |
| 171 | Cumulative trauma disorder | | | |
| 172 | Neck pain or injury | | | |
| 173 | Back injury | | | |
| 174 | Sciatica | | | |
| 175 | Shoulder problem | | | |
| 176 | Wrist/hand/elbow problem | | | |
| 177 | Carpal tunnel syndrome | | | |
| 178 | Knee problem | | | |
| 179 | Ankle/foot problem | | | |
| 180 | Hip problem | | | |
| 181 | Chiropractic treatment | | | |
| 182 | Gout | | | |
| 183 | Osteoporosis | | | |
| 184 | Rhabdomyolysis | | | |
| 185 | Amputation | | | |
| 186 | Fibromyalgia | | | |
| 187 | Scoliosis | | | |

| | | | | |
|---|---|---|---|---|
| 188 | Systemic lupus erythematosus | | | |
| 189 | Dermatomyositis | | | |
| 190 | Scleroderma | | | |
| 191 | Problems gripping, lifting, or reaching | | | |
| 192 | Problems with kneeling or squatting | | | |

**Skin** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 193 | Abscess | | | |
| 194 | Frequent bruising | | | |
| 195 | MRSA infection of the skin | | | |
| 196 | Frostbite | | | |
| 197 | Eczema or hives | | | |
| 198 | Psoriasis | | | |

**Sleep issues** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 199 | Sleep apnea | | | |
| 200 | Narcolepsy | | | |
| 201 | Shift work disorder | | | |
| 202 | Insomnia | | | |
| 203 | Any other sleep disorder | | | |
| 204 | Difficulty falling asleep | | | |
| 205 | Waking up during the night | | | |
| 206 | Trouble staying awake during the day | | | |
| 207 | Have you been told that you snore? | | | |
| 208 | Have you often tired during the day? | | | |
| 209 | Do you know if you stop breathing while you are asleep? | | | |
| 210 | Has anyone witnessed you stop breathing while you are asleep? | | | |
| 211 | Are you tired after sleeping? | | | |
| 212 | Are you tired during wake time? | | | |
| 213 | Have you ever fallen asleep while driving? | | | |

**Mental health** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 214 | Depression | | | |
| 215 | Difficulty concentrating | | | |
| 216 | Suicide attempt | | | |
| 217 | Thoughts of suicide | | | |
| 218 | Treatment by psychiatrist | | | |
| 219 | Treatment by psychologist | | | |
| 220 | Counseling | | | |
| 221 | Hospitalization for mental problem | | | |
| 222 | Anxiety | | | |
| 223 | Psychosis | | | |
| 224 | Bipolar disease | | | |
| 225 | Schizophrenia | | | |
| 226 | Hallucinations | | | |
| 227 | Use of recreational drugs | | | |
| 228 | Alcohol abuse | | | |
| 229 | Alcoholism | | | |
| 230 | Addiction | | | |
| 231 | Attention deficit disorder | | | |
| 232 | Post-traumatic stress disorder | | | |

| | | | | |
|---|---|---|---|---|
| 233 | Feeling stressed most of the time | | | |
| 234 | Panic attacks | | | |
| 235 | Claustrophobia | | | |
| 236 | Fear of heights | | | |
| 237 | Amnesia | | | |
| 238 | Learning disability | | | |
| 239 | Have you ever felt you should cut down on your drinking? | | | |
| 240 | Have people annoyed you by criticizing your drinking? | | | |
| 241 | Have you ever felt bad or guilty about your drinking? | | | |
| 242 | Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? | | | |
| 243 | During the past month, have you often been bothered by feeling down, depressed or hopeless? | | | |
| 244 | During the past month, have you often been bothered by little interest or pleasure in doing things? | | | |

**Allergies** – *Have you ever had or have you now any of the following?*

| | | | | |
|---|---|---|---|---|
| 245 | Do you have any allergy? | | | |
| 246 | Seasonal allergies | | | |
| 247 | Anaphylaxis (severe allergy) | | | |
| 248 | Allergic reactions that interfere with your breathing | | | |
| 249 | Allergy to medications | | | |
| 250 | Allergy to food | | | |
| 251 | Allergy to cayenne or chili peppers | | | |
| 252 | Allergy to latex | | | |
| 253 | Allergy to metals | | | |
| 254 | Allergy to bee stings | | | |
| 255 | Allergy to plant (e.g., poison ivy) | | | |
| 256 | Allergy to cats | | | |
| 257 | Allergy to dogs | | | |
| 258 | Allergy to fumes | | | |
| 259 | Allergy to dust | | | |
| 260 | Has a medical professional suggested that you carry an Epi-Pen? | | | |
| 261 | Other allergies (please list) | | | |

Do you use any medical appliances or implanted medical devices not previously mentioned?

☐ Yes ☐ No

If yes, please explain:

**Do you *CURRENTLY* have any of the following symptoms of pulmonary or lung illness?**

| | | Yes | No | If yes, provide details with date of onset and date of recovery |
|---|---|---|---|---|
| 262 | Shortness of breath | | | |
| 263 | Shortness of breath when walking fast on level ground or walking up a slight hill or incline | | | |
| 264 | Shortness of breath when walking with other people at an ordinary pace on level ground | | | |
| 265 | Have to stop for breath when walking at your own pace on level ground | | | |
| 266 | Shortness of breath when washing or dressing yourself | | | |
| 267 | Shortness of breath that interferes with your job | | | |
| 268 | Coughing that produces phlegm (thick sputum) | | | |
| 269 | Coughing that wakes you early in the morning | | | |
| 270 | Coughing that occurs mostly when you are lying down | | | |
| 271 | Coughing up blood in the last month | | | |
| 272 | Wheezing | | | |
| 273 | Wheezing that interferes with your job | | | |
| 274 | Chest pain when you breathe deeply | | | |
| 275 | Any other symptoms that you think may be related to lung problems | | | |

Have you ever used a respirator? ☐ Yes ☐ No

If you have used a respirator, have you ever had any of the following problems?

- Eye irritation ☐ Yes ☐ No
- Skin allergies or rashes ☐ Yes ☐ No
- Anxiety that occurs only when you use the respirator ☐ Yes ☐ No
- Unusual weakness or fatigue ☐ Yes ☐ No
- Any other problem that interferes with your use of a respirator ☐ Yes ☐ No

Provide details where necessary. Do not leave any question blank. Do not use "white out" or correction tape. Additional information must be documented on the attached "Supplemental Information" sheet.

## Supplemental Information

*Additional space for further explanation and information relating to medical history:*

# CERTIFICATION

*Read the following carefully before signing this certification. A false answer to any question in this statement may be grounds for disqualification and may be punishable by fine or imprisonment. Failure to disclose a disease, condition, medication, or any other information that affects or could affect your ability to perform the essential job functions or that could endanger others is grounds for immediate termination and is possibly a crime.*

I have completed this statement with the knowledge and understanding that any or all items contained herein may be subject to investigation and I consent to the release of information concerning my capacity and fitness by employers, educational institutions, law enforcement agencies, and other individuals and agencies, to duly accredited investigators, and other authorized employees of _____ [name of Agency] for that purpose.

My signature below attests that all information that I have reported is true and correct to the best of my knowledge, and that I have not knowingly omitted to report any material information relevant to this form.

I authorize physicians designated by _____ [name of Agency] to perform a medical examination and necessary medical tests for to determine if I am medically able to perform the essential job functions of law enforcement officer. I understand that this information will be treated as a confidential medical record by _____ [name of Agency] in accordance with state and federal law.

SIGNATURE _____ DATE _____

PRINT NAME _____ (applicant)

## Medical Provider Review

I certify that I reviewed the Medical History Form provided by _____ [name of Applicant], discussed responses and appended the form as appropriate.

_____ _____

Medical provider signature Date

_____

Medical provider name

## Release of Records

I authorize any of the doctors, hospitals, or clinics mentioned in my Medical History Form to furnish _____ [name of Agency] a complete transcript of my medical record for purposes of processing my application for employment as law enforcement officer.

I authorize physicians designated by _____ [name of Agency] to release my medical examination records to _____ [name of Agency] for employment consideration as a police officer, with the stipulation that the released information be kept confidential and used solely for the purposes of determining my medical qualification. In addition, I hereby grant _____ [name of agency] permission to release my medical records to the reviewing physicians designated by _____ [name of Agency].

SIGNATURE _____ DATE _____

PRINT NAME _____ (Applicant)

# Pre-Placement Physical Examination Form

Date of Examination: _____

Name of Applicant: _____

**Vital signs**

Weight _____ Height _____ BMI _____

Blood pressure _____/_____ Heart rate _____ Waist circumference _____

**Vision**

Visual acuity, distant, without correction: LT _____ RT _____ Both _____
Visual acuity, distant, with correction: LT _____ RT _____ Both _____
Visual acuity, near, without correction: LT _____ RT _____ Both _____
Visual acuity, near, with correction: LT _____ RT _____ Both _____
Peripheral vision: LT _____ RT _____
Color vision (type of test and score): _____

| Eyes | Unremarkable | Abnormal Findings |
|---|---|---|
| Pupils | | |
| Conjunctivae | | |
| Eyelids | | |
| Extraocular motions | | |

| Ears, nose, mouth, and throat | Unremarkable | Abnormal Findings |
|---|---|---|
| Oropharynx | | |
| Teeth | | |
| Ear canals | | |
| Tympanic membranes | | |
| Nose | | |
| Deformity of face | | |
| Deformity of skull | | |

| Neck | Unremarkable | Abnormal Findings |
|---|---|---|
| Trachea (midline) | | |
| Jugular vein distention | | |
| Cervical lymphadenopathy | | |
| Carotid bruit | | |
| Mass | | |
| Thyroid | | |

| Cardiorespiratory | Unremarkable | Abnormal Findings |
|---|---|---|
| Heart auscultation | | |
| Lung auscultation | | |
| Pedal pulses | | |
| Leg edema | | |

| Abdomen | Unremarkable | Abnormal Findings |
|---|---|---|
| Hernia | | |
| Mass | | |

| | | |
|---|---|---|
| Scars | | |
| Tenderness | | |
| Rigidity | | |
| Bowel sounds | | |
| Enlarged liver | | |
| Enlarged spleen | | |

| Spine | Unremarkable | Abnormal Findings |
|---|---|---|
| Scars | | |
| Deformity | | |
| Curvature | | |
| Tenderness | | |
| Straight leg raise | | |
| Walk on toes and on heels | | |
| Range of motion of cervical spine (flexion/extension) | | |
| Range of motion of cervical spine (rotation) | | |
| Range of motion of lumbar spine (flexion/extension) | | |

| Upper extremities | Unremarkable | Abnormal Findings |
|---|---|---|
| Deformity | | |
| Range of motion | | |
| Tenderness | | |
| Atrophy | | |
| Amputation | | |

| Lower extremities | Unremarkable | Abnormal Findings |
|---|---|---|
| Deformity | | |
| Range of motion | | |
| Tenderness | | |
| Atrophy | | |
| Amputation | | |

| Neurological | Unremarkable | Abnormal Findings |
|---|---|---|
| Posture | | |
| Gait | | |
| Mental status (alertness, orientation, memory) | | |
| Speech | | |
| Finger to nose | | |
| Cranial nerves | | |
| Deep tendon reflexes | | |
| Light touch sensation | | |
| Strength (biceps, triceps, knees, ankles) | | |
| Tandem walk | | |
| Romberg | | |
| Tremors | | |

| Skin | Unremarkable | Abnormal Findings |
|---|---|---|
| Rash | | |
| Lesions | | |

| Psychiatric | Unremarkable | Abnormal Findings |
|---|---|---|
| Mood and affect | | |
| Judgment | | |

| Optional examinations | Unremarkable | Abnormal Findings |
|---|---|---|
| Genitourinary | | |
| Rectal exam | | |
| Breast exam | | |

**Comments:**

Signature of Medical Provider

Name of Medical Provider

# Immunization Worksheet for Law Enforcement Officers 2014

Based upon Reference: http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-bw.pdf

Last Name First Name DOB

**Medical Notes (allergies, vaccine reactions, etc.):**

**Immunizations:**

| Vaccine | Formulation & Manufacturer | Date Given | Administered By: | Lot Number | Expiration | Next Dose |
|---|---|---|---|---|---|---|
| **Diphtheria/Tetanus/Pertussis** | | | | | | |
| Recommend: Substitute 1-time dose of Tdap for Td booster, then boost with Td every 10 years | | | | | | |
| **Hepatitis B** | | | | | | |
| 3-dose series. Not needed to restart series if dose is missed per schedule; just pick up where immunization series left off and complete. | | | | | | |
| **Varicella** | | | | | | |
| 2-dose series now part of routine childhood immunizations. Administer for all persons who lack documentation of vaccination or have no evidence of previous vaccine. | | | | | | |
| **Zoster** | | | | | | |
| 1 dose at age 60, regardless of prior episode of zoster (shingles) | | | | | | |
| **Influenza** | | | | | | |
| 1 dose annually | | | | | | |

# Appendix A:

## Medical Release Form for Physical Fitness Test

I hereby certify that the following individual:

_____ [complete name of applicant]

was examined by me on _____ [date].

I have read the description of the fitness test. It is my opinion that the above-named individual is capable of safely participate in vigorous physical exercise with no restrictions. I certify that this individual is able to safely participate in all components of the fitness test, and to exercise at an aerobic level of at least 12 METs.

☐ Yes ☐ No

The issues of particular concern include – but are not limited to – cardiovascular diseases (such as hypertrophic cardiomyopathy, arrhythmia and coronary artery disease), asthma, serious lung disease, significant musculoskeletal conditions and history of exertional rhabdomyolysis and risk factors for rhabdomyolysis (such as thyroid disease, renal disease, statin use, sickle cell trait, and sickle cell disease).

_____ _____

Signature of licensed medical provider Date

_____ _____ _____

Printed name of licensed medical provider Phone number Fax number

**TENNESSEE**
**PEACE OFFICER STANDARDS AND TRAINING COMMISSION**

## CONFIRMATION OF MEDICAL EXAMINATION

(To be completed by a licensed medical examiner)

OFFICER:_____ SSN:_____

AGENCY: MEMPHIS POLICE DEPARTMENT

### TO THE HEAD OF LAW ENFORCEMENT AGENCY

This form should be presented to the medical examiner for the purpose of police officer certification. Upon completion of physical evaluation, the examiner should sign the appropriate statement and this form should be returned to the law enforcement agency. This form should then be attached to the Application for Certification – Police Officer, and should be forwarded to the POST Commission.

### TO THE MEDICAL EXAMINER

Pursuant to Tennessee Code Annotated, Section 38-8-106, applicants for police certification must have passed a physical examination by a licensed physician or a nurse practitioner or physician assistant, so long as the task is expressly included in the written protocol developed jointly by the supervising physician and the nurse practitioner or physician assistant, whichever is applicable, setting forth the range of services that may be performed by the nurse practitioner or physician assistant. Upon completion of evaluation, please sign the appropriate statement and return this document to the law enforcement agency.

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CONFIRMATION STATEMENT OF ATTENDING PHYSICIAN

I have performed a medical examination and find that this officer is:

☐ PHYSICALLY FIT – This person is physically fit within reasonable degree of medical certainty.

☐ NOT PHYSICALLY FIT – This person is not physically fit for the following reasons:

_____

_____

_____

Comment: _____

_____

_____
(Signature of Medical Examiner)

2831 AIRWAYS BLVD STE 102A
(Street Address)

_____
(Date)

901-348-0200
(Telephone)

MEMPHIS, TENNESSEE
(City/State)

RDA #1494
IN-1778 10/4/13